



Workplace Injury / Illness Investigation Report

DATE

NAME OF INJURED EMPLOYEE

DEPARTMENT/AREA OF OCCUANCE	JOB TITLE	REPORTED DATE OF INJURY/ ILLNESS
EMPLOYEE START DATE	LENGTH OF TIME ON JOB OF INCIDENT	NAME OF INDIVIDUAL REPORTED TOO

DISCRIBE INJURY	SPECIFY PART OF BODY AFFECTED	SUDDEN OR GRADUAL ONSET
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CRITICAL INJURY (as defined by Reg. 834) NO YES	IF YES WAS THE MIINISTRY OF LABOUR NOTIFIED
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DISCRIBE , ANY SUBSATNCES , EQUIPMENT, OR THING THAT CAUSED THE INJURY OR ILLNESS

INDICATE THE SPACIFIC TYPE OF MEDICAL ASSITANCE PROVIDED AND BY WHOM (i.e. First aid , medical or other)

DISCRIBE IN DETAIL WHAT HAPPENED TO CAUSE THE INJURY OR ILLNESS (attach additional information or diagrams)

DISCRIBE IN DETAIL THE CORRECTIVE ACTION TAKEN BY WHOM TO PREVENT FURTHER INCIDENTS

Employee Signature Date

Supervisor Signature Date